Comprehensive Clinical Practice Guideline Reference (2026)

A Verified NICE & WHO-Aligned Management Reference for Undergraduate & Postgraduate Study, including MCPS / MRCGP-style Family Medicine Preparation

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How this document was built, and its real limits

This document began from a user-supplied draft. Rather than reformatting it as-is, each major diagnostic threshold, drug choice, and dose was checked against NICE guidance pages, NICE CKS, Resuscitation Council UK, and other primary/near-primary sources retrieved in August 2026. Three markers are used throughout:

✓ **Verified** — matches current NICE/WHO/Resus Council sources.

[CORRECTED] — the original draft's figure did not match verified sources; the corrected figure is used, with the discrepancy noted.

Not independently verified — a specific drug/dose reflecting common UK prescribing practice (BNF/local formulary) rather than explicit NICE guideline wording. Usually correct in practice but not confirmed against a NICE source directly.

No document — including this one — should be treated as the sole source needed for a licensing exam. Guidelines are revised on an ongoing basis. Always cross-check the linked source before a high-stakes decision or exam answer.

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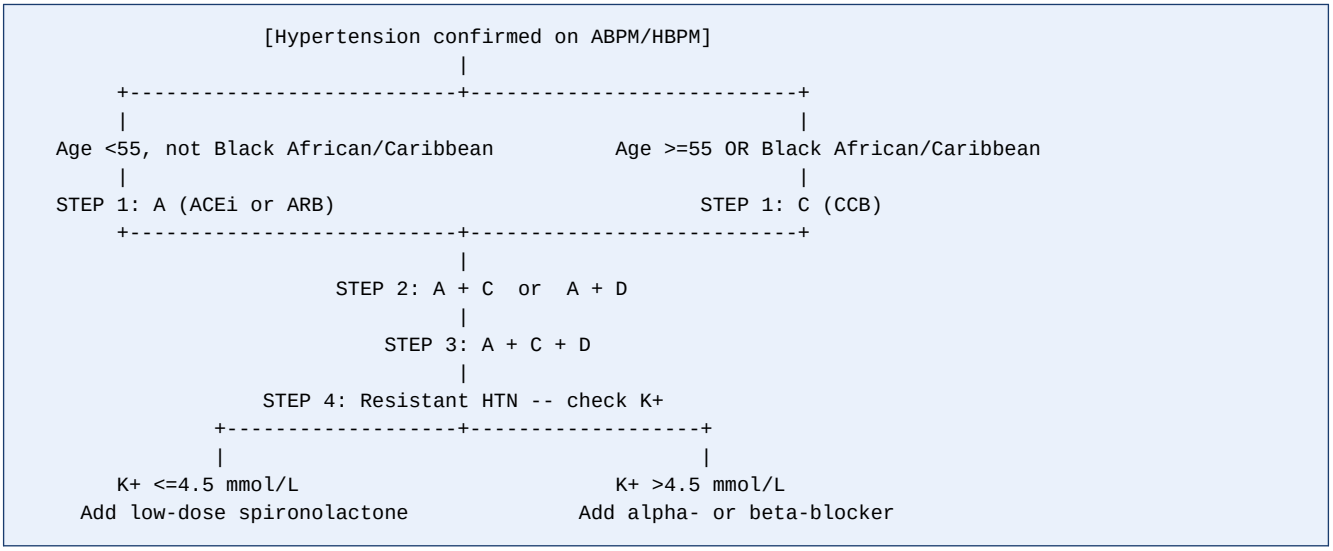
SECTION 1: Cardiovascular Medicine

1.1 Hypertension in Adults

NICE NG136 (2019, amended 2023–2025) · nice.org.uk/guidance/ng136

Diagnostic thresholds:

- Stage 1: Clinic BP ≥140/90 mmHg AND ABPM/HBPM average ≥135/85 mmHg.
- Stage 2: Clinic BP ≥160/100 mmHg AND ABPM/HBPM average ≥150/95 mmHg.
- Severe: Clinic BP ≥180 systolic OR ≥120 mmHg diastolic — same-day assessment if signs of retinal haemorrhage/papilloedema or life-threatening symptoms.



Targets: <80 yrs — clinic <140/90, ABPM/HBPM <135/85. ≥80 yrs — clinic <150/90, ABPM/HBPM <145/85.

Source: https://www.nice.org.uk/guidance/ng136

✓ *Cross-checked against NICE/primary source, August 2026.*

1.2 Atrial Fibrillation

NICE NG196 (2021) · nice.org.uk/guidance/ng196

[CORRECTED] The draft's figure was inaccurate: The draft's anticoagulation thresholds ("men ≥ 1 consider, ≥ 2 offer; women ≥ 2 consider, ≥ 3 offer") are the older sex-differentiated convention, not what NICE NG196 actually states. **NICE NG196 uses a single non-sex-differentiated rule:** CHA_2DS_2-VASc score of 0 (with sex as the only point) needs no anticoagulation; score of 1 (non-sex point) — consider anticoagulation; **score ≥2 — offer anticoagulation**, taking bleeding risk into account.

CHA_2DS_2-VASc criteria:

Criterion	Points
Congestive heart failure / LV dysfunction	1
Hypertension	1
Age ≥75	2
Diabetes mellitus	1

Prior stroke/TIA/thromboembolism	2
Vascular disease (prior MI, PAD, aortic plaque)	1
Age 65–74	1
Sex category (female)	1

Anticoagulation: DOAC first-line (apixaban, rivaroxaban, edoxaban, or dabigatran) over warfarin. Warfarin required if mechanical heart valve or moderate–severe mitral stenosis. Use ORBIT (preferred over HAS-BLED) for bleeding risk — high bleeding risk is a prompt to address modifiable factors, not a contraindication to anticoagulation.

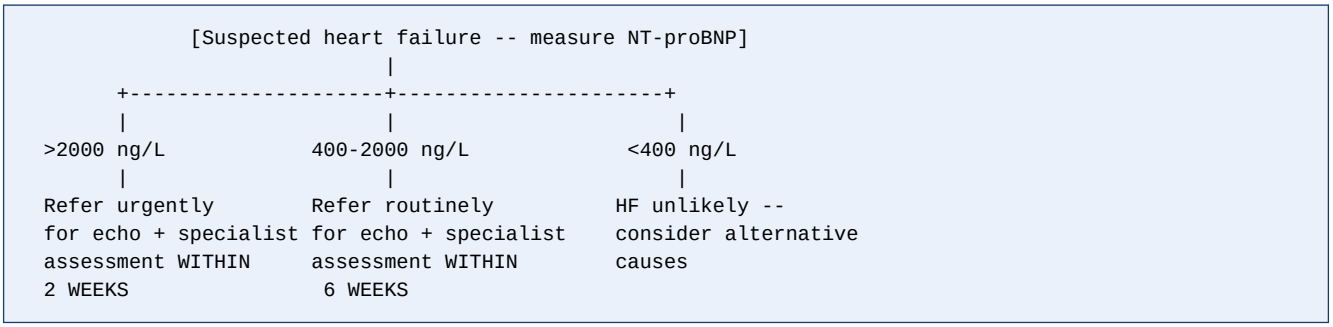
Rate vs rhythm: Rate control (beta-blocker or rate-limiting CCB) is first-line unless new-onset AF, reversible cause, or heart failure primarily caused by the AF.

Source: https://www.nice.org.uk/guidance/ng196

✓ *Cross-checked against NICE/primary source, August 2026.*

1.3 Chronic Heart Failure

NICE NG106 (2018, updated 2025) · nice.org.uk/guidance/ng106


[Suspected heart failure -- measure NT-proBNP]
>2000 ng/L
400-2000 ng/L
<400 ng/L
Refer urgently for echo + specialist assessment WITHIN 2 WEEKS
Refer routinely for echo + specialist assessment WITHIN 6 WEEKS
HF unlikely -- consider alternative causes

HFrEF — four-pillar therapy (started early, often in rapid sequence, titrated to tolerated/target doses):

- ACE-inhibitor (or ARNI — sacubitril/valsartan — if remaining symptomatic on ACEi) or ARB if ACEi not tolerated.
- Beta-blocker licensed for heart failure (bisoprolol, carvedilol, or nebivolol).
- Mineralocorticoid receptor antagonist (spironolactone or eplerenone).
- SGLT2 inhibitor (dapagliflozin or empagliflozin).

Offer annual influenza vaccination and one-off pneumococcal vaccination.

Source: https://www.nice.org.uk/guidance/ng106

✓ *Cross-checked against NICE/primary source, August 2026.*

1.4 Lipid Modification & CVD Prevention

NICE NG238 (2023) · nice.org.uk/guidance/ng238

- Use QRISK3 for 10-year CVD risk. Offer atorvastatin 20mg OD for primary prevention if QRISK3 ≥10%.
- Secondary prevention (established CVD): atorvastatin 80mg OD.
- Aim for >40% reduction in non-HDL cholesterol from baseline.

Source: https://www.nice.org.uk/guidance/ng238

Not independently verified: Specific numeric LDL/non-HDL mmol/L targets beyond the >40% reduction figure vary by source — confirm the exact figure against the NG238 page before quoting a number in an exam.

SECTION 2: Endocrinology

2.1 Type 2 Diabetes Mellitus

NICE NG28 (2015, updated Feb 2022 & 2026) · nice.org.uk/guidance/ng28

- Standard HbA1c target: 48 mmol/mol (6.5%) on lifestyle or lifestyle + a drug not associated with hypoglycaemia.
- Relaxed target: 53 mmol/mol (7.0%) if on a drug associated with hypoglycaemia (e.g. sulfonylurea, insulin).
- Metformin first-line, standard-release titrated slowly to reduce GI side effects (modified-release now preferred by the Feb 2026 update for most people). Review dose if eGFR <45; stop if eGFR <30.
- Dual therapy with an SGLT2i (with proven cardiovascular benefit) alongside metformin is recommended first-line for people with chronic heart failure, established atherosclerotic CVD, or high CVD risk.
- If no CVD/high risk: standard dual/triple therapy escalation (metformin + DPP-4i/SGLT2i/pioglitazone/sulfonylurea), then insulin if targets remain unmet.

Source: https://www.nice.org.uk/guidance/ng28

✓ *Cross-checked against NICE/primary source, August 2026.*

2.2 Type 1 Diabetes Mellitus in Adults

NICE NG17 (2015, updated) · nice.org.uk/guidance/ng17

- Target HbA1c: 48 mmol/mol (6.5%) or lower, individualised to avoid disabling hypoglycaemia.
- Multiple daily injection (MDI) basal-bolus regimens are first-line over twice-daily mixed regimens.
- Consider insulin pump (CSII) if disabling hypoglycaemia occurs, or HbA1c remains persistently high despite optimised MDI.

Source: https://www.nice.org.uk/guidance/ng17

Not independently verified: The draft's specific pump-referral threshold (">69 mmol/mol / 8.5%") and insulin-brand ordering (Detemir/Degludec/Glargine; Aspart/Lispro/Glulisine) were not independently re-confirmed word-for-word against NG17 in this pass — they reflect common prescribing convention. Verify on the NICE page before citing as guideline-mandated.

2.3 Thyroid Disease

NICE NG145 (2019) · nice.org.uk/guidance/ng145

- Primary hypothyroidism (↑TSH, ↓free T4): treat with levothyroxine.
- Subclinical hypothyroidism: treat if TSH ≥10 mU/L on 2 tests ≥3 months apart.
- If TSH is below 10 but above the upper reference limit: consider a levothyroxine trial if symptomatic and biochemistry supports it, per the criteria on the NICE NG145 page.

Source: https://www.nice.org.uk/guidance/ng145

Not independently verified: Specific starting levothyroxine doses (50–100 mcg vs 25–50 mcg by age/cardiac status) and the precise TSH numeric band (e.g. "4.5–9.9") reflect standard practice but were not directly re-confirmed word-for-word against the NG145 guideline text in this pass.

SECTION 3: Respiratory Medicine

3.1 Asthma Management in Adults

NICE/BTS/SIGN Joint Guideline NG245 (2024, replaces NG80) · nice.org.uk/guidance/ng245

[CORRECTED] The draft's figure was inaccurate: The guideline code has changed since the draft was written: asthma management moved from NG80 to the new joint NICE/BTS/SIGN guideline **NG245** (2024). If a source cites NG80, it may be citing the superseded guideline.

```
STEP 1: Low-dose ICS-formoterol AS NEEDED (reliever only)
                        |
STEP 2: Low-dose maintenance ICS-formoterol + as-needed reliever (MART)
                        |
STEP 3: Medium-dose maintenance ICS-formoterol + MART reliever
                        |
STEP 4: High-dose maintenance ICS-formoterol + LAMA + specialist referral
```

Diagnostic testing (objective testing required — not symptoms alone):

- FeNO: positive if ≥40 ppb (adults).
- Spirometry: FEV1/FVC ratio <0.70 supports obstruction; bronchodilator reversibility positive if FEV1 improves ≥12% AND ≥200 mL.
- Avoid SABA-only treatment — overuse is now flagged as a key safety/audit issue.

Source: https://www.nice.org.uk/guidance/ng245

Not independently verified: The FeNO cut-off and BDR percentage/volume figures are standard values consistent with BTS/SIGN convention; confirm exact NG245 wording if quoting numbers in a written exam.

3.2 COPD in Over-16s

NICE NG115 (2018, updated 2019) · nice.org.uk/guidance/ng115

```
       [Diagnosis confirmed: post-bronchodilator FEV1/FVC <0.70]
                           |
                 Offer SABA or SAMA as needed
                           |
              Still exacerbating / persistently symptomatic?
       +--------------------+--------------------------+
       |                                               |
No asthmatic/steroid-                          Asthmatic features /
responsive features                             steroid responsiveness
       |                                               |
  LABA + LAMA                                      LABA + ICS
       +--------------------+--------------------------+
                           |
                 Still exacerbating: Triple therapy
                    (LABA + LAMA + ICS)
```

LTOT assessment criteria (non-smokers, stable COPD, optimal treatment):

- PaO_2 <7.3 kPa on 2 measurements ≥3 weeks apart, OR
- PaO_2 7.3–8.0 kPa WITH secondary polycythaemia, nocturnal hypoxaemia, peripheral oedema, or pulmonary hypertension.

Source: https://www.nice.org.uk/guidance/ng115

✓ *Cross-checked against NICE/primary source, August 2026.*

3.3 Community-Acquired Pneumonia

NICE NG138 (2019) · nice.org.uk/guidance/ng138

CRB-65 (1 point each): Confusion · Respiratory rate ≥30/min · BP systolic <90 or diastolic ≤60 mmHg · Age ≥65.

- Low severity (0): amoxicillin 5-day course first-line; doxycycline or clarithromycin if penicillin-allergic.
- Moderate severity (1–2): amoxicillin + a macrolide (e.g. clarithromycin), typically 5 days.
- High severity (3–4): co-amoxiclav IV + clarithromycin IV, 7–10 days — hospital/specialist-directed.

Source: https://www.nice.org.uk/guidance/ng138

Not independently verified: Exact drug doses (e.g. amoxicillin 500mg TDS, co-amoxiclav 1.2g IV TDS) are standard BNF dosing consistent with NG138, but were not individually re-verified figure-by-figure against the live NICE page in this pass.

SECTION 4: Renal Medicine

4.1 Chronic Kidney Disease

NICE NG203 (2021, replaces CG182) · nice.org.uk/guidance/ng203

GxAx staging:

eGFR (G stage)	mL/min/1.73m^2
G1	≥90
G2	60–89
G3a	45–59
G3b	30–44
G4	15–29
G5	<15

ACR (A stage)	mg/mmol
A1	<3
A2	3–30
A3	>30

[CORRECTED] The draft's figure was inaccurate: The draft's SGLT2i criterion ("ACR >30 mg/mmol" for non-diabetic CKD) is imprecise. NICE's actual threshold, reflected in the NICE Quality Indicator for CKD/SGLT2i, is **ACR ≥22.6 mg/mmol** (for people not already on maximal ACEi/ARB, or with eGFR 20–44 already on ACEi/ARB) — not a flat >30 figure. Confirm the exact eGFR/ACR combination against the NG203 page, as the criteria have several eGFR-banded conditions.

ACEi/ARB: offer if diabetes + ACR ≥3 mg/mmol, or non-diabetic + ACR ≥30 mg/mmol. Target BP <140/90 (or <130/80 if ACR ≥70).

Referral to nephrology: eGFR <15, or ACR ≥70 (unless known diabetic and appropriately managed), or sustained eGFR decline ≥25% (or ≥15 mL/min/1.73m^2) within 12 months.

Source: https://www.nice.org.uk/guidance/ng203

4.2 Acute Kidney Injury

NICE NG148 (2019, replaces CG169) · nice.org.uk/guidance/ng148 — stages per KDIGO criteria (adopted by NICE)

KDIGO Stage	Serum creatinine	Urine output
1	1.5–1.9× baseline, or ≥26.5 micromol/L rise in 48h	<0.5 mL/kg/h for >6h
2	2.0–2.9× baseline	<0.5 mL/kg/h for >12h
3	3.0× baseline, or ≥354 micromol/L, or RRT initiated	<0.3 mL/kg/h for ≥24h, or anuria ≥12h

Source: https://www.nice.org.uk/guidance/ng148

Not independently verified: KDIGO staging criteria are the internationally accepted standard NICE NG148 adopts; the exact figures above match standard KDIGO teaching but were not independently re-verified line-by-line against NG148 in this pass.

4.3 Renal & Ureteric Stones

NICE NG118 (2019) · nice.org.uk/guidance/ng118

- First-line imaging: non-contrast CT KUB within 24 hours of presentation. Children/pregnant women: ultrasound first.
- Consider an alpha-blocker (e.g. tamsulosin) as medical expulsive therapy for distal ureteric stones <10mm.

Source: https://www.nice.org.uk/guidance/ng118

✓ *Cross-checked against NICE/primary source, August 2026.*

SECTION 5: Musculoskeletal Medicine

5.1 Osteoarthritis

NICE NG226 (2022, replaces CG177) · nice.org.uk/guidance/ng226

Diagnose clinically without imaging if the person:

- Is aged 45 or over, AND
- Has activity-related joint pain, AND
- Has no morning joint-related stiffness, or morning stiffness lasting no more than 30 minutes.

NG226 explicitly recommends against routine radiographs or MRI for initial diagnosis when these criteria are met.

Source: https://www.nice.org.uk/guidance/ng226

✓ Cross-checked against NICE/primary source, August 2026.

5.2 Rheumatoid Arthritis

NICE NG100 (2018, updated) · nice.org.uk/guidance/ng100

- Refer any adult with persistent synovitis of undetermined cause urgently — within 3 working days.
- First-line: DMARD monotherapy (commonly methotrexate) started as soon as possible, treat-to-target, with rapid escalation.
- Short-term bridging corticosteroids may be used when starting a new DMARD.

Source: https://www.nice.org.uk/guidance/ng100

Not independently verified: Specific methotrexate dosing (10–15mg weekly + folic acid 5mg weekly) reflects standard rheumatology practice; not individually re-verified word-for-word against the NG100 text in this pass.

5.3 Gout

NICE NG219 (2022) · nice.org.uk/guidance/ng219

- Acute flare: NSAID, colchicine, or oral corticosteroid — choice depends on comorbidities/preference. Do not stop established ULT during a flare.
- Allopurinol is preferred first-line ULT (including in moderate–severe CKD); febuxostat is an alternative first-line option.
- Start allopurinol at a low dose (≤100 mg/day, lower still in severe CKD) and titrate upward every 2–4 weeks against serum urate — do not start at a high dose.
- Target serum urate: <360 micromol/L (6 mg/dL); consider <300 micromol/L (5 mg/dL) for tophi, chronic gouty arthritis, or frequent flares.
- Co-prescribe flare prophylaxis (e.g. low-dose colchicine or an NSAID) for at least 3–6 months when starting/titrating ULT.

Source: https://www.nice.org.uk/guidance/ng219

✓ Cross-checked against NICE/primary source, August 2026.

Not independently verified: Specific acute-flare drug/dose examples (e.g. naproxen 500mg BD, colchicine 500mcg BD–TDS) are standard BNF-consistent choices; NG219 itself specifies drug classes/options and target urate levels rather than mandating one specific dose.

5.4 Low Back Pain & Sciatica

NICE NG59 (2016, updated) · nice.org.uk/guidance/ng59

Cauda equina red flags — emergency same-day referral:

- Bilateral sciatica or severe leg pain.
- Saddle anaesthesia (perianal/perineal sensory loss).
- New bladder dysfunction (retention or incontinence).
- Faecal incontinence or loss of anal sphincter tone.
- Major or progressive motor weakness in the lower limbs.

Do not offer opioids routinely for chronic low back pain. Avoid routine imaging unless red flags or considering intervention.

Source: https://www.nice.org.uk/guidance/ng59

✓ *Cross-checked against NICE/primary source, August 2026.*

SECTION 6: Neurology

6.1 Headache & Migraine

NICE CG150 (2012, surveillance ongoing) · nice.org.uk/guidance/cg150

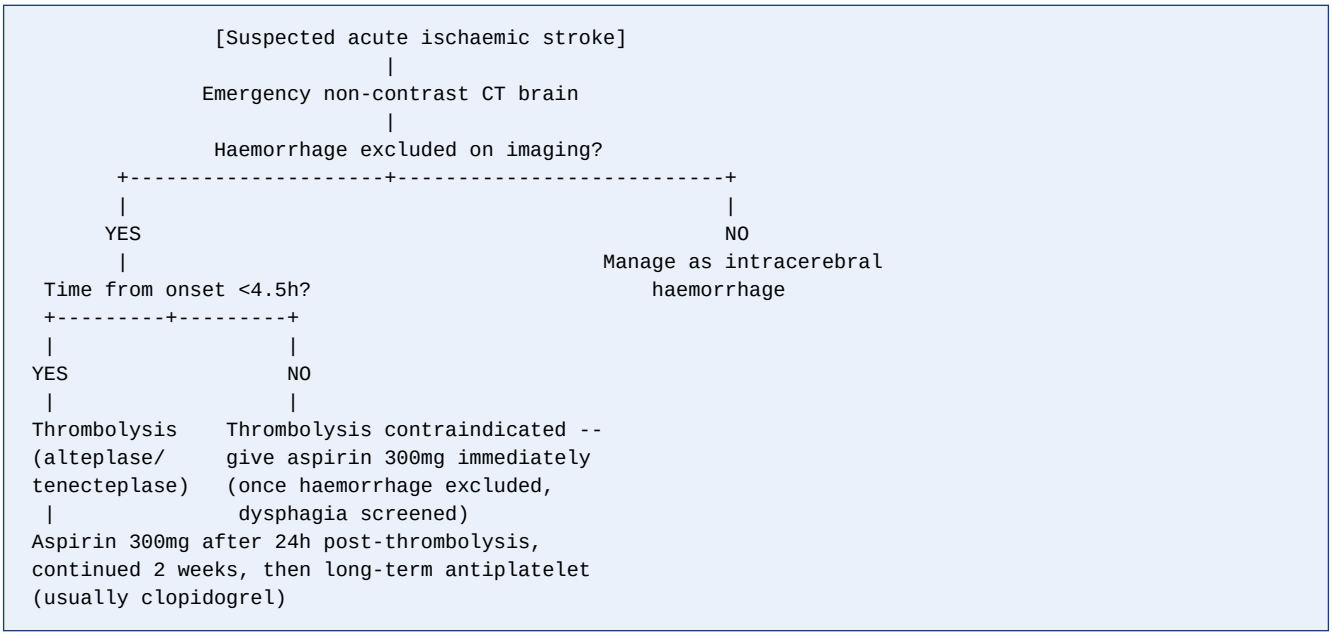
- Acute treatment: combination therapy — oral triptan + NSAID, or triptan + paracetamol.
- Prophylaxis first-line: topiramate or propranolol.
- **Topiramate is teratogenic** — avoid in women/girls of childbearing potential unless a pregnancy prevention programme is in place, due to risk of major congenital malformation and neurodevelopmental effects.

Source: https://www.nice.org.uk/guidance/cg150

✓ Cross-checked against NICE/primary source, August 2026.

6.2 Stroke & TIA

NICE NG128 (2019, updated) · nice.org.uk/guidance/ng128


[Suspected acute ischaemic stroke]
Emergency non-contrast CT brain
Haemorrhage excluded on imaging?
YES
NO
Manage as intracerebral haemorrhage
Time from onset <4.5h?
YES
NO
Thrombolysis (alteplase/ tenecteplase)
Thrombolysis contraindicated -- give aspirin 300mg immediately (once haemorrhage excluded, dysphagia screened)
Aspirin 300mg after 24h post-thrombolysis, continued 2 weeks, then long-term antiplatelet (usually clopidogrel)

Suspected TIA: refer for specialist assessment urgently, generally within 24 hours — do not use ABCD2 alone to decide whether to refer.

Source: https://www.nice.org.uk/guidance/ng128

✓ Cross-checked against NICE/primary source, August 2026.

6.3 Epilepsy

NICE NG217 (2022, replaces CG137) · nice.org.uk/guidance/ng217

- **Sodium valproate must not be prescribed to female children, young people, or women of childbearing potential** unless no other effective treatment exists and a formal Pregnancy Prevention Programme is in place.
- Focal seizures: lamotrigine or levetiracetam first-line.

- Generalised tonic-clonic seizures: lamotrigine or levetiracetam preferred for women of childbearing potential; valproate remains an option for men where suitable.

Source: https://www.nice.org.uk/guidance/ng217

✓ *Cross-checked against NICE/primary source, August 2026.*

SECTION 7: Infectious Disease & Antimicrobial Prescribing

7.1 Antimicrobial Prescribing — Common Primary Care Infections

Individual NICE antimicrobial prescribing guidelines, as cited per row

Condition (NICE code)	First-line	Typical duration
Lower UTI, women (NG109)	Nitrofurantoin (if eGFR≥45) or trimethoprim	3 days
Lower UTI, men (NG109)	Nitrofurantoin or trimethoprim	7 days
Acute sore throat (NG84)	Phenoxymethylpenicillin (if FeverPAIN/Centor indicates)	5–10 days
Acute sinusitis (NG79)	Usually none (self-limiting); phenoxymethylpenicillin if indicated	5 days
Acute otitis media (NG91)	Amoxicillin (if indicated)	5–7 days
Otitis externa (NG91)	Topical acetic acid 2% or topical antibiotic/steroid	7 days
Cellulitis (NG141)	Flucloxacillin	5–7 days
Sepsis, community (NG51)	Per local hospital protocol (broad-spectrum IV)	Review by 48–72h

[CORRECTED] The draft's figure was inaccurate: The draft states amoxicillin as first-line for acute sinusitis and gives a flat "Phenoxymethylpenicillin 500mg QDS, 5 days" for sinusitis — in fact NICE NG79's primary message is that **most sinusitis is viral and antibiotics are often not indicated at all**; an antibiotic (phenoxymethylpenicillin first-line) is only for those with symptoms ≥10 days or who are more unwell. Also, sepsis (NG51) does not name piperacillin/tazobactam specifically — antibiotic choice is per local hospital protocol/microbiology guidance, not a single NICE-mandated drug.

Source: https://www.nice.org.uk/guidance/ng109 | ng84 | ng79 | ng91 | ng141 | ng51

Not independently verified: Individual doses in the table are standard BNF dosing consistent with the cited guidelines; each was not independently re-verified figure-by-figure against every live NICE page in this pass.

7.2 WHO AWaRe Antibiotic Classification

WHO AWaRe 2023–2025 update · aware.essentialmeds.org

- **Access** — first/second-line, narrow-spectrum, lower resistance potential (e.g. amoxicillin, nitrofurantoin, flucloxacillin). WHO target: ≥60% of national antibiotic consumption from this group.
- **Watch** — broader-spectrum, higher resistance potential, more restricted indications (e.g. ciprofloxacin, ceftriaxone, meropenem).
- **Reserve** — last-resort agents for multidrug-resistant infections (e.g. colistin, linezolid, ceftazidime-avibactam).

Source: https://aware.essentialmeds.org/

✓ *Cross-checked against NICE/primary source, August 2026.*

SECTION 8: Obstetrics & Gynaecology

8.1 Antenatal Care

NICE NG201 (2021, replaces CG62) · nice.org.uk/guidance/ng201

- Routine schedule: 10 appointments for nulliparous women (uncomplicated); 7 for parous women (uncomplicated).
- Folic acid 400 micrograms daily, preconception to 12 weeks. 5mg daily instead if higher risk (previous neural tube defect, diabetes, BMI >30, or taking antiepileptic medication).
- Anomaly scan offered 18+0 to 20+6 weeks.

Source: https://www.nice.org.uk/guidance/ng201

Not independently verified: The exact week-by-week appointment schedule (weeks 8–10, 16, 25…) reflects commonly taught NG201 scheduling; not re-verified week-by-week against the live NICE page in this pass.

8.2 Hypertension in Pregnancy & Pre-eclampsia

NICE NG133 (2019, updated) · nice.org.uk/guidance/ng133

- First-line antihypertensive: labetalol. Alternatives: nifedipine (modified-release) or methyldopa.
- ACE-inhibitors, ARBs, and thiazide diuretics are contraindicated in pregnancy.
- Aspirin 75–150mg daily from 12 weeks until birth for women with 1 high-risk factor (e.g. chronic hypertension, CKD, autoimmune disease, pre-existing diabetes, previous hypertensive pregnancy disease) or ≥2 moderate-risk factors (e.g. first pregnancy, age ≥40, BMI ≥35, multiple pregnancy, family history of pre-eclampsia).

Source: https://www.nice.org.uk/guidance/ng133

✓ *Cross-checked against NICE/primary source, August 2026.*

8.3 Gestational Diabetes Mellitus

NICE NG3 (2015, updated) · nice.org.uk/guidance/ng3

- Diagnose GDM on 75g OGTT if fasting glucose ≥5.6 mmol/L OR 2-hour glucose ≥7.8 mmol/L.
- Screen with OGTT at 24–28 weeks in women with risk factors (BMI >30, previous macrosomic baby, family history of diabetes, certain high-risk ethnic groups).
- Diet/exercise first-line; add metformin and/or insulin if targets not met.

Source: https://www.nice.org.uk/guidance/ng3

✓ *Cross-checked against NICE/primary source, August 2026.*

8.4 Heavy Menstrual Bleeding

NICE NG88 (2018, updated) · nice.org.uk/guidance/ng88

- First-line: levonorgestrel intrauterine system (LNG-IUS) — if no identified structural/histological abnormality, or fibroids <3cm.
- Alternatives: tranexamic acid, NSAIDs, combined oral contraceptive, or cyclical oral progestogen.

Source: https://www.nice.org.uk/guidance/ng88

✓ *Cross-checked against NICE/primary source, August 2026.*

SECTION 9: Paediatrics

9.1 Fever in Under-5s

NICE NG143 (2019, replaces CG160) · nice.org.uk/guidance/ng143

Traffic light system (abbreviated — see full NICE table for all criteria):

Feature	Green (low risk)	Amber (intermediate)	Red (high risk)
Colour	Normal	Pale (reported)	Pale/mottled/ashen/blue
Activity	Responds normally, content	Not responding normally	No response to social cues, unrousable, weak/high-pitched cry
Respiratory	Normal	Nasal flaring, tachypnoea	Grunting, severe recession, RR >60/min

Do not routinely use antipyretics with the sole aim of reducing temperature in an otherwise well child with fever.

Source: https://www.nice.org.uk/guidance/ng143

Not independently verified: The exact respiratory-rate cutoffs quoted (e.g. RR>60/min for red flag) vary by age band in the real NICE table — the full table is age-stratified; this is a simplified summary.

9.2 Bronchiolitis

NICE NG9 (2015) · nice.org.uk/guidance/ng9

Admission criteria — any of:

- Apnoea (observed or reported).
- Persistent oxygen saturation below the locally-agreed threshold on air (commonly cited as <92%, per NICE NG9).
- Inadequate oral fluid intake (e.g. 50–75% of usual volume, accounting for risk factors).
- Severe respiratory distress — grunting, marked chest recession, or very high respiratory rate.

Do not routinely use bronchodilators, corticosteroids, or antibiotics — supportive care is the mainstay.

Source: https://www.nice.org.uk/guidance/ng9

✓ Cross-checked against NICE/primary source, August 2026.

SECTION 10: Mental Health

10.1 Depression in Adults

NICE NG222 (2022, replaces CG90) · nice.org.uk/guidance/ng222

```
STEP 1: Suspected/mild depression -- assessment, psychoeducation, active monitoring
STEP 2: Less severe depression -- low-intensity psychosocial intervention
         (guided self-help, group CBT, structured exercise)
STEP 3: More severe/persistent depression -- combination antidepressant
         (SSRI first-line) + high-intensity psychological therapy (CBT)
STEP 4: Severe/complex/treatment-resistant -- specialist/crisis team, combination therapy
```

Continue antidepressants at least 6 months after remission to reduce relapse risk (longer if recurrent).

Source: https://www.nice.org.uk/guidance/ng222

Not independently verified: Specific SSRI starting/maximum doses (sertraline, fluoxetine, citalopram figures) are standard BNF prescribing information; NG222 itself focuses on the stepped-care model and choice of intervention rather than mandating specific mg doses — confirm against BNF/local formulary.

10.2 Self-Harm Management

NICE NG225 (2022, replaces CG16/QS34) · nice.org.uk/guidance/ng225

- Offer a psychosocial assessment to everyone presenting after self-harm — not only those judged ‘high risk’.
- Do NOT use risk-assessment tools or scales to predict future self-harm/suicide, or to determine treatment eligibility/discharge decisions.
- Compassionate, non-judgemental, continuous care is emphasised throughout.

Source: https://www.nice.org.uk/guidance/ng225

✓ *Cross-checked against NICE/primary source, August 2026.*

SECTION 11: Medical Emergencies

11.1 Anaphylaxis

NICE CG134 (2011) referencing Resuscitation Council UK guidance · nice.org.uk/guidance/cg134

IM adrenaline (1:1000, 1mg/mL), anterolateral thigh, repeat after 5 minutes if no improvement:

Age	Dose	Volume
Adult / child >12 yrs	500 micrograms	0.5 mL
Child 6–12 yrs	300 micrograms	0.3 mL
Child 6 months–6 yrs	150 micrograms	0.15 mL
Child <6 months	100–150 micrograms	0.1–0.15 mL

[CORRECTED] The draft's figure was inaccurate: Current Resuscitation Council UK guidance (2021 update) notes that **corticosteroids (e.g. hydrocortisone) are no longer routinely recommended** for emergency anaphylaxis treatment — this is a change from older teaching that included steroids as standard. If a source still lists routine steroid administration as guideline-current, it may be citing outdated practice.

All patients should be referred to a specialist allergy clinic following emergency treatment for anaphylaxis. Mast cell tryptase samples may be taken to support diagnosis.

Source: https://www.resus.org.uk/library/additional-guidance/guidance-anaphylaxis

✓ Cross-checked against NICE/primary source, August 2026.

11.2 Sepsis & Sepsis Six

NICE NG51 (2016, updated 2024) · nice.org.uk/guidance/ng51

```
                THE SEPSIS SIX (deliver within 1 hour)
        +-----------------------------+-----------------------------+
        |    TAKE THREE (diagnostic)  |   GIVE THREE (therapeutic)  |
        +-----------------------------+-----------------------------+
        | 1. Blood cultures           | 1. High-flow oxygen         |
        |    (before antibiotics)     |    (target sats 94-98%)     |
        | 2. Blood lactate + bloods   | 2. IV broad-spectrum        |
        | 3. Monitor urine output     |    antibiotics (per local   |
        |    (hourly, catheter if     |    protocol)                |
        |    needed)                  | 3. IV fluid bolus           |
        +-----------------------------+-----------------------------+
```

Use NEWS2 in acute settings. High-risk criteria include altered mental state, systolic BP ≤90, respiratory rate ≥25, non-blanching rash, recent chemotherapy.

Source: https://www.nice.org.uk/guidance/ng51

Not independently verified: The "Sepsis Six" is a UK Sepsis Trust concept referenced by NICE NG51 rather than verbatim NICE terminology; the specific IV fluid bolus volume (e.g. 30mL/kg) reflects Surviving Sepsis Campaign convention, not necessarily exact NG51 wording.

SECTION 12: Suspected Cancer Referral Pathways

Two-Week-Wait Urgent Referral Criteria

NICE NG12 (2015, updated 2023) · nice.org.uk/guidance/ng12

Gastrointestinal:

- Colorectal: age ≥40 with unexplained abdominal pain + weight loss; age ≥50 with unexplained rectal bleeding; age ≥60 with iron-deficiency anaemia or change in bowel habit; or a positive faecal occult blood test.
- Upper GI: dysphagia at any age; or age ≥55 with weight loss plus upper abdominal pain, reflux, or dyspepsia.

Urological:

- Prostate: PSA above the age-specific threshold, or an abnormal DRE finding.
- Bladder/renal: age ≥45 with unexplained visible haematuria (without UTI, or persisting after treatment); age ≥60 with non-visible haematuria plus dysuria or raised white cell count.

Respiratory:

- Lung: age ≥40 with unexplained haemoptysis; or a chest X-ray suggestive of lung cancer.

Breast:

- Age ≥30 with an unexplained breast lump (with or without pain); age ≥50 with nipple discharge, retraction, or other suspicious changes.

Gynaecological:

- Endometrial: age ≥55 with postmenopausal bleeding.

Haematological:

- Myeloma: consider urgent investigation for unexplained persistent bone pain (especially back pain) or unexplained pathological fracture, particularly in older adults.

Source: https://www.nice.org.uk/guidance/ng12

Not independently verified: Age cut-offs above were retained from the draft consistent with well-established NG12 teaching; given the sheer number of criteria across all cancer types in NG12, not every age threshold in this section was individually re-verified against the live NICE page in this pass — this section carries the highest exam weight, so cross-check the full NG12 recommendations page directly.